American Samoa Department of Health
COVID 19 Health Clearance Form

Public Health
Prevent. Promote. Protect.
American Samoa
Department of Health

All travelers will be transported directly to an ASDOH Quarantine Site for further medical evaluation and COVID-19 testing. You will be required to complete 14-day Quarantine per ASDOH policy and medical evaluation criteria. If you have completed any prior COVID-19 test and/or Quarantine in another country you are encouraged to bring official documentation with you for review. Quarantine in another country and/or results of prior COVID-19 test DOES NOT guarantee a waiver of full 14-day Quarantine, so please be prepared to stay in full 14-day Quarantine. All cases will be evaluated and monitored by the ASDOH medical team.

Have you ever tested positive for COVID19? YES ☐ NO ☐

If yes, please provide TWO Negative COVID19 test results or medical certificate, indicating you have been cleared of SARS-CoV-2 virus infection to dohcovid19clearance@doh.as. You will not be allowed entry into Am. Samoa until 28 days from the date of the second COVID19 test, indicating you have been cleared of the virus.

TRAVELER'S INFORMATION & DEMOGRAPHICS

Traveler's name (First, Last) _____ **Hospital#** _____

Date of Birth date ___/___/___ **Sex:** ☐ F ☐ M ☐ Other **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Samoan ☐ Tongan ☐ Fijian ☐ Filipino ☐ Asian ☐ White ☐ Black ☐ Other_____

Phone _____ **Email** _____ **Village of Residence:** _____

City/State/Zip/County _____ **American Samoa resident** ☐ Yes ☐ No

Medical Information:
Do you require Renal Dialysis?: ☐ YES ☐ NO

Do you have any disabilities or special needs? ☐ YES ☐ NO If "**YES**" , PLEASE SPECIFY ANY SPECIAL NEEDS WE MAY NEED TO ACCOMMODATE DURING QUARANTINE: _____

PLEASE SPECIFY ANY ALLERGIES TO FOOD OR MEDICATION:_____

PLEASE SPECIFY ANY DIETARY RESTRICTIONS:_____

SECTION TO BE FILLED BY A MEDICAL OFFICER

Height _____ (cm) Weight _____(kg) Temperature _____(oC) Respiratory rate: _____

Pulse _____ Regular or Irregular (circle one) Blood pressure _____SYS) / _____ (DIA) Oxygen saturation _____%

COVID19 Vaccination: Have you received the COVID19 Vaccine? ☐ YES ☐ NO

If "YES, Please specify: **Manufacturer:**_____ 1st Dose date: _____ 2nd Dose date:_____

CLINICAL FEATURES

Y	N	Unk	
☐	☐	☐	**Any fever, subjective or measured**
☐	☐	☐	Chills or rigors
☐	☐	☐	Headache
☐	☐	☐	Myalgia (muscle aches or pains)
☐	☐	☐	Pharyngitis (sore throat)
☐	☐	☐	Sinus congestion
☐	☐	☐	**Cough**
☐	☐	☐	Productive cough Onset date ___/___/___
☐	☐	☐	Dry cough Onset date ___/___/___
☐	☐	☐	**Dyspnea (shortness of breath)**
☐	☐	☐	**Pneumonia**
☐	☐	☐	Nausea / Vomiting
☐	☐	☐	Diarrhea
☐	☐	☐	Abdominal pain or cramps
☐	☐	☐	Sudden loss of taste or smell
☐	☐	☐	Other symptoms _____

Predisposing Conditions

Y	N	Unk	
☐	☐	☐	Current tobacco smoker
☐	☐	☐	Diabetes mellitus
☐	☐	☐	Chemotherapy
☐	☐	☐	Steroid therapy
☐	☐	☐	Cancer diagnosis or treatment in 12 months prior to
☐	☐	☐	onset Organ transplant
☐	☐	☐	Immunosuppressive therapy, condition or disease
☐	☐	☐	Chronic heart disease
☐	☐	☐	Asthma/reactive airway disease
☐	☐	☐	Chronic lung disease (e.g., COPD, emphysema)
☐	☐	☐	Chronic liver disease
☐	☐	☐	Chronic kidney disease
☐	☐	☐	Hemoglobinopathy (e.g., sickle cell disease)
☐	☐	☐	Current prescription or treatment
☐	☐	☐	Hemodialysis at time of onset
☐	☐	☐	Other underlying medical conditions _____

☐ I certify that all information above is correct and the person whose name is mentioned in the "Traveler's Information & Demographics" section above is Medically Stable and Fit for travel

_____ Print Name of Medical Official & Titile

_____ Signature & Date

Other Notes: